Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Lonestar DME
1509 Falcon Drive, Ste. 106
Desoto, TX 75115

MFDR Tracking #: M4-05-B411-01

Sent
AUG 08 2006
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

Respondent Name and Box #:

St. Paul Fire & Marine Insurance
Rep. Box #: 05

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "...Lonestar DME received a TWCC-62 for date of service April 8, 2005 stating Eo745-RR and E073 were denied due to "Not Appropriately Documented". On May 26, 2005 via fax "Request for Reconsideration" was sent to the carrier, according to Rule 133.304, with a cover letter detailing the providers' position for the Reconsideration and documentation to support the charges, as well a letter of medical necessity from the treating doctor for the DME supplied to this patient... At this time the carrier has not responded to the "Request for Reconsideration", therefore violating Rule 133.304, which allows for 28- days for a response, thus resulting in Lonestar DME being entitled to dispute resolution under Rule 133.305 citing the carrier has violated Rule 133.304 Section (i) which clearly states, "An insurance carrier shall treat a request for reconsideration as an incomplete medical bill under Rule 133.300 of this title...if the request is not submitted in accordance with subsection (k) of this section. Within 21 days of receiving the request for reconsideration the insurance carrier shall take final action on the medical bill as described in subsection (b) of this section". It is presumed that subsection (k) was met since the reconsideration sent on May 26, 2005 was complete and received by the carrier via fax... and not returned to the requestor as incomplete. The carrier did not respond in the time set forth in Section (i)...if the request is not submitted in accordance with subsection (k) of this section, and again the carrier can not claim they did not received the request for reconsideration, because attached you will find confirmation this Request for Reconsideration was sent via fax to the carrier..."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $000.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

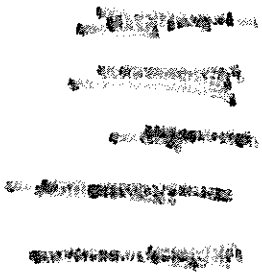
Respondent's Position Summary: "...Concentra's Provider Bill Review department has reviewed the above mentioned date of service and found that the bill was processed and denied correctly. This was the first bill received from this provider on this claim. The provider billed for the rental of a neuromuscular stimulator and the form-fitting conductive garment. The supporting documentation did not include all the required information such as the duration of use. This was requested. We never received a response or a request for reconsideration from the provider. If the provider has sent a request for reconsideration there would be another EOR..."

Principle Documentation:

1. Response to DWC 60
2. Affidavit of Non-existence of Business Record

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	HCPCS Codes and Calculations	Denial Reasons	Part V Reference	Amount Ordered
04/08/05	E0745-RR	N (885)	1 – 4	$0.00
04/08/05	E0731	N (885)	1 – 4	$0.00
Total:				$0.00



PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "N (885) – Not appropriately documented. The service, procedure, and or supply, requires additional information which may include identifying code, type, frequency, duration and or quantity. Please resubmit with DOP/Script to include length of duration."
2. The Respondent states in their position summary that they never received a request for reconsideration and has submitted a signed and notarized affidavit that states, "As of 8/23/2005, there is no record of a scanned medical bill having been received from Lonestar DME regarding [injured worker]..."
3. The Requestor has submitted EOR's with a carrier received date of 04/18/2005 and has also submitted a faxed confirmation sheet showing a request for reconsideration was made on 05/26/2005 to fax number 972-374-4828 at 15:23 pm with 9 pages being sent. Therefore, per 28 Texas Administrative Code (TAC) Section 133.307(e)(2)(B) the Requestor has submitted convincing evidence of the carrier receipt of the request for reconsideration.
4. The Respondent denied both HCPCS codes for not being appropriately documented and requested that the provider resubmit with DOP/Script to include length of duration. Review of the Requestor's submitted documentation does not document the length of duration of the treatment. Therefore, per 28 TAC Section 134.202(c)(2)(A) reimbursement is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section. 413.011(a-d);
- Texas Labor Code Section. 413.031;
- Texas Labor Code Section. 413.0311;
- 28 Texas Administrative Code Section 133.307
- 28 Texas Administrative Code Section 134.1;
- 28 Texas Administrative Code, Section 134.202; and
- Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor III Medical Fee Dispute Resolution	August 8, 2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.